

File

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>01-004</u>	2. STATE: <u>VT</u>
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE <u>June 1, 2001</u>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <u>42 C.F.R. § 440.20(a)</u>		7. FEDERAL BUDGET IMPACT: a. FFY <u>02</u> \$ _____ b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 4.19-B Page 2a(1) (01-04)</u>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <u>Attachment 4.19-B Page 2a(1) (99-15A)</u>	
10. SUBJECT OF AMENDMENT: <u>Addition of Methadone Treatment Services to Medicaid Reimbursement Hospital Outpatient Services</u>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <u>John J. Lashley Jr. Sec. Kathleen C. Ryan</u>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <u>[Signature]</u>		16. RETURN TO: Roxanne Doty Department of Prevention, Assistance, Transition, and Health Access 103 South Main Street Waterbury, VT 05671-1201	
13. TYPED NAME: <u>Ms. Jane Kitchel</u>		17. DATE RECEIVED: <u>6-29-01</u>	
14. TITLE: <u>Secretary, Agency of Human Services</u>		18. DATE APPROVED: <u>7-5-01</u>	
15. DATE SUBMITTED: <u>July 2, 2001</u>		FOR REGIONAL OFFICE USE ONLY	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>6-1-01</u>		PLAN APPROVED - ONE COPY ATTACHED	
21. TYPED NAME: <u>Ronald Preston</u>		20. SIGNATURE OF REGIONAL OFFICIAL: <u>Margaret Hon for R. Preston</u>	
23. REMARKS:		22. TITLE: <u>Associate Regional Administrator</u>	

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METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES --- OTHER
MEDICAL CARE (continued)

2. a. Outpatient Hospital Services

For all Vermont hospitals and the following New Hampshire hospitals (Dartmouth-Hitchcock, Cheshire, Valley Regional, Alice Peck Day, Cottage, Upper Connecticut Valley, Weeks Memorial, and Littleton Regional), payment is made on an interim basis at a hospital specific interim percentage of charge subject to year-end audit and cost-adjustment in accordance with the Title XVIII principles of Reasonable Cost Reimbursement (42 CFR Part 413) with the following exceptions:

1. Services normally furnished in a physician's office are paid using the physician fee schedule. No payment is made for the hospital "facility fee" or overhead, and hospital costs attributable to these services are not allowed for outpatient hospital cost settlement.
2. Psychiatric partial hospitalization services are paid at per diem rates with no year-end cost settlement.
3. Laboratory services are paid at the lesser of the actual charge, the RVU (the RVU price is the price on file based on a relative value scale for lab services) price or the Medicare maximum allowable amount with no year-end cost settlement.
4. Radiology services as defined in 42 CFR §413.122 are paid at the lesser of actual charge, the Medicaid price on file or the Medicare maximum allowable amount with no year-end cost settlement.
5. Observation care services are paid at the lesser of the hospital's percentage of the charge for not more than 24 hours of outpatient care with a year-end cost settlement or the hospital's per diem rate for a medical/surgical day without a year-end cost settlement.
6. Methadone treatment services are paid at the lesser of the hospital's charge or the Medicaid rate on file with no year end cost settlement.

All other hospitals will be reimbursed at the mean percentage of the interim rates for Vermont and the New Hampshire hospitals listed above for services rendered with no year-end cost settlement.

TN# 01-04
Supersedes
TN# 99-15 A

Effective Date: 6/1/01

Approval Date: 7/5/01